



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: COMPLETE MED CARE ASSOCIATES 6776 SOUTHWEST FREEWAY HOUSTON TX 77074	MFDR Tracking #: M4-11-3856-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE COMPANY Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary in the DWC060 dispute packet.
Amount in Dispute: \$12,000.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided pain management services from 4/11/11 through 4/26/11 without preauthorization." "Failure to preauthorize resulted in no reimbursement." "No payment is due."
Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
04/11/2011	97799-CP	Not Applicable – Preauthorization Not Obtained	\$1,200.00	\$0.00
04/12/2011			\$1,200.00	
04/13/2011			\$1,200.00	
04/14/2011			\$1,200.00	
04/15/2011			\$1,200.00	
04/18/2011			\$1,200.00	
04/19/2011			\$1,200.00	
04/20/2011			\$1,200.00	
04/25/2011			\$1,200.00	
04/26/2011			\$1,200.00	
Total Due:			\$0.00	

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
4. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - CAC-197 — PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
 - 786 — DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
 - CAC-193 — ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 724 — NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Tex. Admin. Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code Section 413.014(b) states "the insurance carrier is not liable for those specified treatments and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission." 28 TAC §134.600(c)(1)(B) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury...only when the following situations occur...preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care." 28 TAC §134.600(p)(10) requires preauthorization for "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted documentation finds that the Requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 TAC §134.600.
2. Review of the submitted documentation finds that the Requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 TAC §134.600. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Medical Fee Dispute Resolution Officer

08/30/2011

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.